M HR-RM 1
(11-1-56)
Hall of Records Commission

REQUEST FOR RECORDS RETENTION SCHEDULE

To be Submitted to the Records Management Division
Hall of Records Commission

File

SCHEDULE NO. 600

PAGE NO. 1.

1. Requesting Agency	2. Division or Bureau of Requesting Agency
STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE	COUNTY HEALTH DEPARTMENT RECORDS

3. Authorization Requested (Check only one of the squares below).

A ☐ Dispose of present accumulation. No additional accumulation is anticipated. Records have ceased to have value to warrant retention.

B ☒ Establish retention schedule for records for which there is a continuing accumulation. The records will cease to have value to warrant their retention after the period of time indicated.

C ☐ Microfilm and destroy originals. Originals if not microfilmed would be retained for the period of time indicated.

4. Item No.	5. Description of Records Describe records accurately. Include title, form number, size of documents, work or activity to which the records relate, inclusive dates, and quantity (cubic or linear feet). Show recommended retention period.	6. Recommendation of Hall of Records and Board of Public Works.
1.	DENTAL HEALTH RECORDS The dental records in the County Health Departments are maintained in family folders or in individual case folders. These records include: Pre-school Dental Examination, such as DH-12 Treatment Record, such as DH-13 Dental Inspection, such as DH-20 RECOMMENDATIONS: RETAIN FOR THREE YEARS AFTER DATE OF LAST ENTRY AND THEN DESTROY.	
2.	TUBERCULOSIS REGISTER All counties maintain a tuberculosis register, most often on a form similar to TB-14, which shows: patient's name, address, age, sex, race, occupation, marital status, whether veteran, date reported, physician, prognosis, results of laboratory and X-ray examinations, clinic visits, drug refills, and remarks. A contact record on a form similar to TB-14A is also maintained showing names of individuals with whom a tubercular patient is closely associated. Information regarding the patient is summarized on a History Card maintained on all tuberculosis patients in Maryland in the central file of the Division of Respiratory Diseases, State Department of Health. The recommendation below applies only to the county tuberculosis registers. RECOMMENDATION: RETAIN UNTIL DEATH OF PATIENT AND THEN DESTROY.	

7. Agency, Division or Bureau Representative

Thomas M. Thomas	Dir. of Administration	11/28/73
Signature	Title	Date

Schedule Authorized as Indicated in Col. 6 by Hall of Records Commission.

11/7/74	Marion E. Russell	
Date	Archivist	

Disposal Authorized as Indicated in Col. 6 by Board of Public Works.

	Louis L. Goldstein
Date	Secretary

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3.	MASS CHEST X-RAY SURVEY DATA Mobile chest X-ray units visit the counties periodically. The following records result from this operation. Thirty-five (35) millimeter film containing X-ray pictures, each of which is identified by number. IBM punch cards showing the X-ray number, individual's name, address, race, and result of X-ray examination. These cards are sent to the counties in numerical order. IBM - Tabulation Sheets printed from the punch card and showing the same information. Lists of names of individuals whose X-rays indicate the possibility of tuberculosis and other abnormalities being present. These lists are in alphabetical order and show the patient's name, address, and X-ray number. After the film is read and the lists prepared, all film and cards are forwarded to the county. None of the counties are equipped to read the film; the tabulation lists of negative results and the IBM cards are used only occasionally. These few instances of reference occur when a subsequent X-ray shows the presence of tuberculosis and the diagnostician wishes to check on the earlier X-ray. Individuals whose X-ray shows positive or doubtful tuberculosis are asked to return for further examination and if indicated their names are placed in the tuberculosis register in the County Health Department, and a case history folder is initiated in the county. RECOMMENDATION: RETAIN FOR FIVE YEARS AND THEN DESTROY.	
4.	TUBERCULOSIS REPORTS SHOWING NEGATIVE RESULTS Records concerning an individual examined for tuberculosis with negative results include equivalents of: TB - 23 Physician's Report - The County Health Officer's report to family physician regarding patient referred to the County Tuberculosis Clinic. TB - 6 Tuberculosis Record BL - 9 Laboratory Report X-ray Film Correspondence RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.	
5.	TUBERCULOSIS CASE RECORDS The following records are among those included in this item:	

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Tuberculosis Record, such as TB - 6, shows patient's name, address, physical description, employment, name of physician, previous tuberculosis or other signigicant medical history, present symptoms, X-ray interpretation, extent of present tuberculous disease, recommendations, results of sputum analysis, results of tuberculin tests, and notes of physician and public health nurse.

Tuberculosis Contact Record, such as TB-6b, of tubercular findings of contacts of known tubercular patients.

Application for Admission to and discharge from Maryland Tuberculosis Hospitals, such as TB - 2.

Social Service Face Sheet Information, such as TB - 12, on TB patients.

Public Health Nurse's Report on Patient and Home Situation for Tuberculosis Hospitals, such as TB - 18.

Physician's Report, such as TB - 23, County Health Officer's report to family physician regarding patient referred to County Tuberculosis Clinic (if positive diagnosis).

X-ray films

RECOMMENDATION: RETAIN UNTIL DEATH OF INDIVIDUAL OR FOR FIFTY YEARS, WHICHEVER OCCURS EARLIER, AND THEN DESTROY.

6. TUBERCULOSIS CORRESPONDENCE - GENERAL

Correspondence concerned with chest clinics and mass chest X-ray survey. It is with Federal, State, local and other state agencies, civic and professional organizations, physicians, etc.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

7. CHEST CLINIC MONTHLY REPORTS

Chest Clinic Monthly Report studies, such as TB - 15. This is a statistical record of each day's activities in the county chest clinics.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

8. COMMUNICABLE DISEASE RECORD

Specific diseases must be reported to the County Health Officer by the physician making the diagnosis. The health officer is further

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required to keep a record of such reported diseases (Art. 43, Secs. 78 and 79, Annotated Code of Maryland 1957 Edition).

The Physician reports the disease on a standard post-card, such as U.S. Public Health Service form No. 1407 or State Health Department Form CD-1 and the County Health Department records the information in a register maintained for that purpose or on another card. In either instance the original form is forwarded to the State Department of Health. The information shown in the county record is: name of disease, patient's name, address, date of onset, hospital, school, place of work, any remarks, and the name of the physician making the diagnosis. The recommendation below applies only to the duplicate records maintained by the County Health Departments.

RECOMMENDATION: RETAIN FOR FIVE YEARS AND THEN DESTROY.

9. VENEREAL DISEASE CLINIC RECORDS - SYPHILIS

The following records are maintained as case files on individuals having this infection:

Venereal Disease Registration and Preliminary Examination Record, such as VD - 25D.

Venereal Disease History Chart, such as CD - 25, and Treatment Card

Laboratory Reports and correspondence may be destroyed immediately after summarization and entry on above forms.

RECOMMENDATION: RETAIN FOR TWENTY-FIVE YEARS AFTER LAST ENTRY, OR UNTIL DEATH, WHICHEVER IS EARLIER, AND THEN DESTROY

10. VENEREAL DISEASE CLINIC RECORDS - GONORRHEA, CHANCROID, GRANULOMA, INGUINALE AND LYMPHOGRANULOMA VENEREUM

All records of patients having any venereal infection except syphilis.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

11. VENEREAL DISEASE STATISTICAL REPORTS

Venereal Disease Register, such as VD - 47, shows date, patient's name, diagnosis and treatment; prepared weekly.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

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12. IMMUNIZATION RECORD

Such records as MCH-7 and MCH-22 show name, address, ages, sex, race, type(s) of immunization and date(s) of innoculation.

RECOMMENDATION: RETAIN UNTIL INDIVIDUAL COMPLETES SCHOOLING OR HIGH SCHOOL AND THEN DESTROY.

13. MATERNITY AND GYNECOLOGICAL CASE FILES

These clinical records are maintained on forms supplied by the Division of Maternal and Child Health, State Department of Health, or the County Health Department. Generally, maternity case records are retained in family folders which also contain the treatment records of other members of a patient's family. Some counties maintain the records in individual clinic case folders as well as family folders. The records which may be filed in the individual or family folder include:

Maternity Record, such as MCH-8, or MCH8-A, history including present pregnancy

Gynecological clinical data recorded during initial interview with patient and subsequent physical examination

Summaries of re-visit consultations

Correspondence with patient

RECOMMENDATION: RETAIN UNTIL PATIENT REACHES AGE FORTY-FIVE OR UNTIL DEATH, WHICHEVER IS EARLIER, AND THEN DESTROY.

14. PEDIATRIC CASE FILES

Pediatric Clinic records are usually maintained, on forms supplied by the Division of Maternal and Child Health, in family folders which also contain the treatment records of other members of a patient's family. The records include correspondence concerning the patient.

RECOMMENDATION: RETAIN FOR TEN YEARS OR UNTIL PATIENT REACHES TWENTY-ONE, WHICHEVER IS EARLIER, AND THEN DESTROY.

15. HEARING OR VISION, ORTHOPEDIC, CARDIAC, AND PLASTIC CASE FILES

These clinical records are usually maintained on forms devised by the County in family folders which contain the treatment records of other members of a patient's family. The records may include:

Personal and health history such as SCC-13 and SCC-18

Hearing Clinic Record summarizing patient's history and the results of physical examination

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	Results of eye examination or reexamination Vision Test Results Correspondence RECOMMENDATION: RETAIN UNTIL PATIENT REACHES AGE THIRTY, OR UNTIL DEATH, WHICHEVER OCCURS EARLIER, AND THEN DESTROY	
16.	MENTAL HEALTH CASE FILES These clinical records are maintained on forms supplied by the Mental Health Administration, State Department of Health, and also on forms which are locally devised. These records are usually filed in an individual patient's case folder used for clinical purposes. The records which may be filed in the individual folder include: Mental Health Clinic Referral - School Information, Mental Health Clinic - Patient Service Record, such as DMH-1, giving personal information, type of service and condition after treatment, diagnosis, disposition, and record of interviews with patient or others interested in patient, and the date of termination (copy forwarded to Mental Health Administration). Mental Hygiene Clinic Referral - Adult (summarizes patient's personal history) Mental Hygiene Clinic Referral - Child (summarizes patient's personal history) Typescript summaries of interviews with patients Correspondence RECOMMENDATION: RETAIN UNTIL DEATH OF PATIENT AND THEN DESTROY.	
17.	REPORT OF MENTAL HEALTH CLINIC SERVICES This is a statistical report which is prepared at County level and forwarded to the Mental Health Administration. The report summarizes services on a daily, weekly, or monthly basis and gives admissions and terminations during the period covered by the report, totals of various types of services to patients, and the number of man hours spent by clinical staff on community services of various types. RECOMMENDATION: RETAIN FOR FIVE YEARS AND THEN DESTROY.	
18.	GENERAL CORRESPONDENCE This correspondence is concerned with the County Health Officer's functions and the Public Health Nursing program of the county. It	

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is with Federal, State, local and other agencies, professional and civic organizations, individuals, doctors, dentists, hospitals, and public, private, or professional organizations interested in public health administration. Correspondence concerned with individuals for whom some service is performed is not in this category.

RECOMMENDATION: RETAIN FOR TEN YEARS AND THEN DESTROY

19. ENVIRONMENTAL HEALTH INSPECTION FILE

County sanitarians inspect all establishments handling food whether wholesale, retail, processor or farm, recreational areas, public buildings, schools, nursing homes, hospitals, etc. The following inspection forms or equivalents are used:

U. S. Public Health Service Forms

Shucking and Packing Plant, such as USPHS - A
Pasteurization Plant, such as PHS - 723 (SE)
Eating and Drinking Establishments, such as PHS - 985 (SE)
Milk Producer - Distributor, such as 8976-A
Milk Plant - Producer, such as 8976-D

Department of Health and Mental Hygiene Forms

School Lunch Room Sanitation Report, such as SL - 3
Sanitary Report - Cannery, such as F & D 16
Dairy Form (Producer - Distributor), such as F & D 63
Dairy Form (Shipper), such as F & D 63-A
Crab Meat Plants, such as F & D 82
Bottling Plant, such as F & D 100
Zero Locker Inspection Report

Laboratory Results

Bacteriological Water Report, such as BL - 7
General Laboratory Report, such as BL - 20
Sanitary Survey of Shellfish, such as BL - 22
Bacterial Reports on Milk Shippers, such as BL - 25
Bacteriological Examination of Eating and Drinking Utensils, such as BL - 131
Bacteriological Shellfish Report, such as BL - 191
Water Analysis, such as BL - 221 or BL - 222
Bacteriological Report on Swimming Water, such as BL - 243
Chemistry - Food Report, such as BL - 245, 246, or 247
Milk and Related Products, such as BL - 248
Crabmeat Report, such as BL - 273

Locally devised inspection forms are used by a few of the

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county health departments. It is intended that local forms be included in this item.

Inspections are made periodically, generally at least once a year. Where the inspection report or laboratory report indicates the need for some corrective measure, the owner or operator of the establishment is notified and corrective action is generally instituted immediately.

RECOMMENDATION: RETAIN FOR THREE YEARS (OR LONGER WHERE APPROPRIATE) AND THEN DESTROY.

20. SEPTIC SYSTEM FILES

Records on septic systems should be kept until the system is no longer used.

RECOMMENDATION: RETAIN UNTIL SYSTEM IS NO LONGER IN USE AND THEN DESTROY.

21. COMPLAINT FILE - ENVIRONMENTAL HEALTH NUISANCES

Complaints are handled by the county sanitarian. They are received by mail and by phone, in which case a memorandum is prepared. Complaints are investigated immediately and usually settled within thirty days. The file contains the following records:

Record of Complaint - correspondence or telephone memorandum

Sanitarian's report - narrative, shows findings, recommendations, and final results

RECOMMENDATION: RETAIN FOR THREE YEARS OR UNTIL RESOLVED, WHICHEVER IS LONGER, AND THEN DESTROY.

22. MONTHLY REPORT OF ENVIRONMENTAL HEALTH SERVICES

Reports are prepared daily by each sanitarian showing the type and number of establishments inspected and any remarks. These reports are forwarded to the Division of Food Control. This data is also summarized in monthly reports, duplicates of which are forwarded to the Division. The recommendation below applies to the monthly reports and any daily reports which contain information not on the monthly summary.

RECOMMENDATION: RETAIN FOR THREE YEARS AND THEN DESTROY.

23. FISCAL RECORDS

Funds disbursed by County Health Departments come from the Counties, from the State, and from the Federal Government. Since cost-sharing arrangements frequently base the federal share on total

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substantiated expenditures for a particular program, records of any such funds from whatever source must be retained in accordance with the federal guidelines. The following list is representative of such fiscal records:

Expense Voucher, such as BM-2
Reimbursement of Petty Cash, such as BM-2A, Office Expense Account
Summary of Expense Account, such as BM-4, Field Employees - monthly
Mileage Report, such as BM-5
Order for supplies, such as BM-8
Records of Receipts for Revenue Collections, such as DHMH-567
Requisition for supplies, such as BM-9
Invoice, such as BM-11, bill to county commissioners for care of patients in State Department of Health Hospital
Partial Report of Materials Received, such as BM-18A
Daily Sign-in and out Sheet, such as BM-21
Bi-Weekly Attendance Report, such as BM-21A
Statement for Clinic Services, such as SDH-28
Requisition for Specimen Mailing Outfits, such as BL-70A

Billing Material such as Medicare billing forms, supporting documents and forms, charge slips, daily patient census records, or any business and accounting records that refer to specific claims.

Cost Report Material such as all data necessary to support the accuracy of annual cost report entries, original invoices, canceled checks, copies of material used in preparing annual cost reports, cost report forms, schedules and related work sheets, and contracts or records of dealings with outside sources for medical supplies and services.

Medical Record Information such as utilization review committee reports, physician certification and recertifications, discharge summaries, or clinical and other medical records relating to health insurance claims.

Physician Material such as provider-physician agreements on which Part A and Part B allocations are based.

RECOMMENDATION: RETAIN FOR FIVE YEARS AFTER ACCEPTABLE COST REPORTS HAVE BEEN FILED WITH THE INTERMEDIARY FOR THE FEDERAL GOVERNMENT AND THEN DESTROY.